Infinity Medical
LARAE STEMMERMAN, D.O.

905 29th Ave Marion, Iowa 52302 Phone: 319-826-6374 Fax: 319-826-6376

Medical Records Release

Patient's Name:____

Patient's DOB:____

I authorize______________________________to copy and release the specified

records to____.

Please release: ***complete records*** ____ ***x-rays*** ____ ***labs*** ____ ***other*** ____________________

Records are for: ***patient care*** ____ ***insurance claims*** ____ ***personal use*** ____ ***other*** ____

______________________________ ________________

Signature of Patient or Guardian Date

If you are not the patient listed above, what is your name?______________________

If you are not the above patient, what is your relationship to the patient?______________

Authorization for release of info protected by the State:

______**Substace Abuse**
______**Mental Health**
______**Aids/HIV Related**

____

Signature of Patient/Guardian Date

In accordance with current standards and laws, your signature on this form authorizes us to release your medical records to the requested individual or entity. Please consider that our records may contain records from another health care provider or hospital. If you do not want this portion of your record forwarded, you must inform us at the time this form is signed. Please note that we are not otherwise responsible for this info.